BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

PATRICIA C. WHITE Claimant	)	
V.	)	Docket No. 1,058,937
USD 229 Self-Insured Respondent	)	

ORDER

Respondent and its insurance carrier (respondent), by and through Christopher McCurdy, of Overland Park, requested review of Administrative Law Judge Steven J. Howard's November 26, 2014 Award. Claimant appeared by and through Atif Abdel-Khaliq of Kansas City. The Board heard oral argument on April 14, 2015.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the Award's stipulations. The parties stipulated claimant's date of "accident"[1] was November 15, 2011.[2] At oral argument, the parties agreed the Board may consider the AMA *Guides*[3] (hereafter *Guides*).

ISSUES

Claimant alleged injuries by repetitive trauma to her upper extremities from April 1, 2011, through November 15, 2011. The judge concluded claimant proved personal injury by repetitive trauma arising out of and in the course of her employment. Brian Divelbiss, M.D., the court ordered independent medical examiner, apportioned claimant's overall functional impairment between her preexisting diabetes and the residuals of her repetitive trauma. The judge concluded apportioning claimant's impairment was unwarranted and awarded claimant disability benefits based on Dr. Divelbiss' unreduced rating.

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[1] References in the administrative file to an "accident" should refer to "repetitive trauma." The May 15, 2011 amendments to the Kansas Workers Compensation Act differentiate injury by accident and injury by repetitive trauma. In any event, the judge concluded claimant's injuries were due to her repetitive work.

[2] R.H. Trans. at 30.

[3] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based on the fourth edition of the *Guides*.

Respondent requests the Award be reversed, arguing claimant did not prove personal injury by repetitive trauma which arose out of and in the course of her employment. In the alternative, respondent argues Dr. Divelbiss' opinions regarding claimant's impairment and apportionment are uncontradicted and should be adopted. Respondent claims a credit for a temporary total disability (TTD) overpayment. Finally, respondent argues claimant failed to prove the need for future medical treatment.

Claimant maintains the Award should be affirmed. Claimant argues there is no proof she had any upper extremity impairment due to her diabetes. She contends respondent is not entitled to a credit for an alleged TTD overpayment. Lastly, claimant contends the award of future medical treatment was within the judge's discretion.

The issues for review are:

1. Did claimant's injury by repetitive trauma arise out of and in the course of her employment?

2. What is the nature and extent of claimant's disability?

3. Is respondent entitled to a credit for overpayment of TTD benefits?

4. Is claimant entitled to future medical treatment?

FINDINGS OF FACT

Claimant, age 61, began working for respondent as a custodian in 2004. Claimant's job duties included mopping, dusting, setting up tables and emptying trash, in addition to operating a machine to clean floors. Claimant testified all her duties required repetitive use of her arms, with the floor machine requiring constant gripping and holding.

As early as 2006, claimant was being treated for diabetes at College Park Family Care. In November 2006, Jane Brunner, D.O., her primary care physician, noted her diabetes was "uncontrolled."[4] While examining claimant on June 28, 2007, Tim Talbert, M.D., assessed claimant as having "[d]iabetes mellitus, with evidence of early peripheral neuropathy and diabetic nephropathy."[5] The aforementioned records contained no mention of claimant having upper extremity symptoms. In July 2010, Dr. Talbert referred claimant to Michael Sokol, M.D., a diabetes specialist.

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[4] Stipulation - Records of College Park Family Care (filed Oct. 29, 2014) at 42.

[5] *Id*. at 39.

Dr. Sokol examined claimant on July 7, 2010. Dr. Sokol reported claimant was diagnosed with diabetes mellitus at age 40 and was insulin dependent since age 56. Dr. Sokol noted claimant had numbness of her feet and needed an eye exam. Dr. Sokol diagnosed claimant with "Type 2 diabetes mellitus with neuropathy out of control."[6] This report held no mention of claimant having upper extremity complaints.

On September 28, 2010, Dr. Sokol noted claimant had a positive Tinel's sign, left greater than right, and diagnosed her with carpal tunnel syndrome. Dr. Sokol ordered a nerve conduction test (NCT) and prescribed wrist splints. In April 2011, claimant complained of chronic left hand tingling and was referred to "V. Deardorff."[7]

Claimant testified that in April 2011, she began experiencing numbness and tingling in her left hand which gradually moved up her arm to her shoulder. Claimant testified she started using her right hand more and by August 2011, she developed symptoms in her right hand which gradually went up to her shoulder. Claimant testified she reported these problems to her supervisor, but no medical treatment was provided.

Claimant acknowledged having diabetes-related tingling and numbness in her feet and eye difficulties prior to her work-related repetitive trauma. Her diabetes required at least yearly checkups, insulin and medication. By the time of her work-related repetitive trauma, claimant testified she was no longer experiencing symptoms in her feet and "[e]verything was doing good."[8]

Claimant was terminated on November 8, 2011. Claimant stipulated she was terminated for cause.[9]

Claimant sought treatment on her own through Dr. Brunner, whose November 22, 2011 report stated claimant had left wrist pain, numbness and tingling. The doctor noted claimant did repetitive work as a janitor. Dr. Brunner assessed type 2 diabetes and wrist pain. Dr. Brunner referred claimant to Jeffrey Kaplan, M.D., a neurologist.

In December 2011, Dr. Kaplan performed an EMG which showed severe left and moderate right median mononeuropathy at the wrist and mild to moderate left and mild right ulnar neuropathy at the elbow. Dr. Kaplan assessed severe left and moderate to severe right carpal tunnel syndrome and mild to moderate left and mild right ulnar neuropathy at the elbow, which he stated were related to her "work as a custodian."[10]

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[6] Stipulation - Records of Dr. Sokol and Statland Medical Group (filed Oct. 29, 2014) at 23.

[7] *Id*. at 14-15. The record contains no showing claimant went to V. Deardorff.

[8] R.H. Trans. at 21.

[9] P.H. Trans. (Jan. 8, 2013) at 14.

[10] Stipulation - Records of College Park Family Care (filed Oct. 29, 2014) at 5.

On March 20, 2012, at respondent's request, claimant saw Anne Rosenthal, M.D., an orthopedic hand surgeon. Dr. Rosenthal no longer performs surgery and currently provides medicolegal opinions. Dr. Rosenthal reviewed medical records, took a history and performed a physical examination. Dr. Rosenthal diagnosed claimant with diabetic peripheral neuropathy with possible carpal tunnel syndrome and ulnar nerve compression. Dr. Rosenthal recommended a repeat EMG/NCV of both upper extremities looking specifically for a peripheral neuropathy or distal nerve compression, in addition to an EMG/NCV of one of her lower extremities to get a firm diagnosis on whether she has a peripheral neuropathy. These tests were never performed.

In addressing causation, Dr. Rosenthal stated:

> I first want to point out her complaints are not consistent with a distal nerve compression alone. She clearly complains of numbness and tingling in a pattern that is more diffuse than could be caused by carpal tunnel syndrome. Her complaint of numbness that goes up into her forearms is more consistent with diabetic peripheral neuropathy. She had a nerve test on December 8, 2011, and I definitely question peripheral neuropathy based on this nerve test to the absent sensory responses of the ulnar nerve and median nerves, bilaterally. Furthermore, she denies any numbness or tingling in her history to me and also in her deposition prior to April 2011 when this is clearly not the case. Her first consultation with Dr. Sokol, an endocrinologist who she was seeing because of her diabetes being out of control, notes that she had numbness and she was given a diagnosis in July 2010 of a neuropathy. Furthermore, she was given the diagnosis of carpal tunnel syndrome by Dr. Sokol on September 28, 2010. Her diabetes clearly has been out of control for years. She was given that diagnosis back in 2002. She claims she first sought treatment in April and in August, but she was seen by Dr. Sokol in April with regard to her left hand but did not relate it to her work and again he noted this tingling in her hands back in September 2010.
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> Due to the fact she has a diabetic peripheral neuropathy, her work is not the prevailing factor in her bilateral hand numbness. I do believe it is diabetes related.[11]

Following a May 22, 2012 preliminary hearing, the judge ordered an independent medical examination with the first available physician between Brian Divelbiss, M.D., and Lanny Harris, M.D., for the purpose of determining if claimant's condition was causally related to her employment.

On June 30, 2012, claimant saw Dr. Harris. Dr. Harris reviewed medical records, took a history and performed a physical examination. Dr. Harris opined claimant provided vague and irregular responses and did not put forth good effort when demonstrating range of motion. In addressing causation, Dr. Harris stated:

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[11] Rosenthal Depo., Ex. 1 at 4.

> In spite of her unusual physical signs and apparent lack [of] cooperation, this person does have objective findings of bilateral cubital tunnel syndrome and carpal tunnel syndrome. It is more probable than not that her repetitive work at Blue Valley School District was responsible for her developing the entrapment syndromes. Certainly the not well controlled diabetes increased her tendency to develop both neuropathies, but her repetitive work activities were probably the underlying cause.[12]

Dr. Harris testified on September 18, 2012. Dr. Harris testified the records reflected claimant had some neuropathies into her lower extremities from diabetes. Dr Harris testified diabetes can result in neuropathy and interact with carpal tunnel syndrome:

> Well, I don't fully understand why, but there certainly is a relationship that diabetes affects the function of the peripheral nerves and makes them more sensitive and less functional than before. And people can experience the symptoms of numbness and tingling, muscle weakness, and cramping when they have diabetes. It's just an illness, if you will, of the peripheral nerves caused by diabetes. In my opinion the nerves are more sensitive to compression and things [like] that when you have diabetes and it's difficult to sort out sometimes whether the nerve is compressed just from mechanical factors such as pure carpal tunnel syndrome or is it a nerve that's sick from the diabetes. So you have to use electrical studies and just give a judgement about that.[13]

Dr. Harris acknowledged the medical records reflected claimant had uncontrolled diabetes with neuropathy in the lower extremities prior to the onset of her upper extremity complaints, which caused him concern in addressing causation. Dr. Harris opined claimant's job involving repetitive work was the prevailing factor in causing her entrapment syndromes even with the preexisting uncontrolled diabetes. Dr. Harris suggested claimant have carpal tunnel release at the wrist and an ulnar nerve transposition at the elbows.

Following a September 18, 2012 preliminary hearing, respondent was ordered to provide claimant a list of two physicians capable of treating claimant. Claimant was sent to J. Clinton Walker, M.D., who saw claimant on October 18, 2012. He reviewed medical records, took a history and performed a physical examination. Dr. Walker noted claimant had some signs of symptom magnification and tenderness "everywhere,"[14] which could be consistent with peripheral nerve compression, but he also noted she had increased symptoms with testing at the carpal and cubital tunnels. Dr. Walker diagnosed claimant with bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome and recommended bilateral decompression surgery. Dr. Walker stated:

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[12] Harris Depo., Resp. Ex. G at 2.

[13] *Id*. at 11-12.

[14] Stipulation - Records of J. Clinton Walker, M.D. (filed Oct. 29, 2014) at 33.

> She has diffuse symptoms that are more involved than typical carpal and cubital tunnel syndromes, and I strongly suspect that there is a component of peripheral neuropathy that is contributing to her nerve dysfunction.[15]

On October 31, 2012, Dr. Walker performed surgery on claimant's left hand and elbow. On November 12, Dr. Walker ordered physical therapy and released claimant to return to work with a one-pound lifting restriction with the left arm. On December 19, Dr. Walker performed the same surgery on the right side. On December 31, Dr. Walker ordered physical therapy for the right arm and released claimant to return to work with a one-pound lifting restriction with the right and left arms. On April 24, 2013, Dr. Walker placed claimant at MMI, released her to return to work with no restrictions and indicated no further appointment was necessary.

On January 8, 2013, a preliminary hearing was held regarding TTD. Claimant testified she would not have been able to return to work following her release on November 12, 2012 because her left arm was in a cast up to almost her shoulder and she had severe right arm pain. Claimant testified although she was released to return to work on December 19, 2012, she was undergoing physical therapy and her right arm was in a sling. She was scheduled to attend physical therapy until January 21, 2013.

Sidney Cumberland, respondent's risk manager, testified respondent could have accommodated claimant's one-pound lifting restriction when she was released by Dr. Walker on November 12, 2012, if she had not been terminated over a year earlier. Mr. Cumberland testified that if claimant could not schedule her physical therapy after work hours, respondent would have allowed her to attend during work hours and be paid for such appointments.

On January 11, 2013, the judge ordered respondent to pay TTD. The judge found respondent's testimony that it could accommodate claimant's restrictions "inconceivable . . . incredulous" and "improbable."[16]

Following an October 14, 2013 prehearing settlement conference, the judge ordered an independent medical examination with Brian Divelbiss, M.D. Claimant saw Dr. Divelbiss on January 8, 2014. After reviewing medical records, taking a history and performing a physical examination, Dr. Divelbiss diagnosed claimant with: (1) status post bilateral carpal tunnel releases and bilateral ulnar nerve decompression surgeries and (2) longstanding diabetes mellitus with a suspected component of a peripheral neuropathy. In addressing prevailing factor, Dr. Divelbiss stated:

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[15] *Id.*

[16] ALJ Order (Jan. 11, 2013).

> The cause of her preoperative clinical symptoms was likely multi-factorial in that there was a component of nerve compression but also clearly a component of neuropathy related to her diabetes. I believe it is likely that her daily exposure to vibratory tool use would be considered to be the prevailing cause of the onset of her symptoms; however, I believe that the residual symptoms that she still has are more likely to be related to her diabetic neuropathy.[17]

Dr. Divelbiss opined claimant was at MMI and required no permanent work restrictions. He gave claimant an overall 23% impairment rating to the body as a whole. Using table 16 on page 57 of the *Guides*, Dr. Divelbiss assigned a 10% impairment for each wrist (6% to the body as a whole for each wrist) and 10% for each elbow (6% to the body as a whole for each elbow). Dr. Divelbiss opined 50% of claimant's residual impairment was related to her underlying diabetes, which resulted in a 50% reduction in her permanent partial impairment or a 5% impairment at the wrist and a 5% impairment at the elbow in each arm. Using the Combined Values Chart, Dr. Divelbiss indicated claimant sustained a 10% impairment in each arm. In a supplemental letter, Dr. Divelbiss specifically stated 50% of claimant's impairment was due to her underlying diabetes and peripheral neuropathy.

Dr. Rosenthal testified on October 29, 2014. Dr. Rosenthal indicated claimant's medical history was positive for insulin dependent diabetes. Dr. Rosenthal noted people with diabetes are susceptible to nerve compression. Dr. Rosenthal testified claimant's presentation and physical examination (glove-like or entire hand numbness and tingling), "wasn't consistent with carpal tunnel or cubital tunnel alone. I think she probably had some overlying [diabetic] neuropathy."[18] In addressing prevailing factor, Dr. Rosenthal testified, "I felt that because she had the diabetic peripheral neuropathy the work was not the prevailing factor."[19]

On cross-examination, Dr. Rosenthal acknowledged Dr. Sokol's record regarding diabetes mellitus with neuropathy does not reference which particular part of the body is involved, such as the hands or the legs. Dr. Rosenthal opined claimant's condition was from peripheral neuropathy because, while it is similar to carpal tunnel, claimant complained her hands would fall asleep, but did not provide details as to where it occurred on her hands.

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[17] Divelbiss Report (filed Jan. 28, 2014) at 3.

[18] Rosenthal Depo. at 10-11.

[19] *Id.* at 13.

In the November 26, 2014 Award, the judge stated, in part:

1. K.S.A. 44-508(g) mandates "in determining what constitutes 'prevailing factor' in a given case, the Administrative Law Judge shall consider all relevant evidence submitted by the parties." Prevailing as it relates to the term factor means the primary factor, in relation to any other factor.

   The Kansas legislature has determined that the use of prevailing factor is a judicial interpretation and not a medical opinion. Accordingly, the Administrative Law Judge is not bound by any opinion offered by any medical experts herein, but rather bound to make a determination based upon the factors which contributed to claimant's condition. The Administrative Law Judge has carefully reviewed the records that have been submitted by the parties in this claim. Suffice to say that claimant may have suffered some neuropathy prior to her alleged occupational accident, however the records fail to disclose any neuropathy in claimant's upper extremities prior to the incident she complains of herein.

   Accordingly, the Administrative Law Judge specifically finds that claimant's activities for the Respondent were the prevailing factor, the primary factor, considering all relevant evidence, in relationship to any other factor, that claimant's employment caused her carpal tunnel syndrome, and the injuries she sustained to her upper extremities.

   Based upon the provision cited above, the Administrative Law Judge specifically finds that claimant was not taken off work by any physician due to the diagnose[d] problem prior to her surgery, that claimant was not placed on a modified or restricted duty prior to her surgery, the claimant was not advised by any physician that her condition was work related, and accordingly finds that claimant's last date of work, November 15, 2011, is claimant's date of accident.

2. As a result of claimant's occupational accident, she was temporarily totally disabled for a period of 21 weeks, and based upon an average weekly wage of $608.77, she is entitled to compensation at the rate of $405.87 per week for a total of $8[,]523.27.

3. Claimant is entitled to an Award for all medical expenses as a result of her occupational accident and injury. There is no indication in the record that claimant may need future medical expenses at this time, however, in the event the need arises claimant may make proper application to the Office of the Director to cure or relieve the effects of her injury as provided by the Kansas Statue.

4. Based upon the report of Dr. Brian J. Divelbiss, the independent medical examiner, he apportioned claimant's disability based upon underlying diabetes and peripheral neuropathy as a result of her residual symptoms. The Administrative Law Judge after reviewing the entire record finds Dr. Divelbiss's opinion that claimant had underlying peripheral neuropathy in her upper extremities prior to her occupational accident is not supported by the record. Accordingly, and based up[on] the foregoing, there is no reduction in claimant's functional impairment as a result of the

surgery that she underwent and the injuries she sustained. Accordingly, and based upon the foregoing, the claimant is herein entitled to an award of 23% permanent partial disability to the body as a whole for the injury she sustained while working for her former employer.

5. Accordingly, and based upon the foregoing, claimant is entitled to compensation for a 23% permanent partial disability to the body as a whole as follows: The claimant, Patricia C. White, is entitled to 21 weeks of temporary total disability compensation at the rate of $405.87 per week or $8,523.27 followed by 94.07 weeks of permanent partial disability compensation at the rate of $405.87 per week or $38,180.19, making a total award of $46,703.46.[20]

Respondent filed a timely appeal.

PRINCIPLES OF LAW

An employer is liable to pay compensation to an employee incurring personal injury by accident arising out of and in the course of employment.[21] The burden of proof is on claimant. The trier of fact shall consider the whole record.[22]

K.S.A. 2011 Supp. 44-508 provides, in pertinent part:

> (e) "Repetitive trauma" refers to cases where an injury occurs as a result of repetitive use, cumulative traumas or microtraumas. The repetitive nature of the injury must be demonstrated by diagnostic or clinical tests. The repetitive trauma must be the prevailing factor in causing the injury. "Repetitive trauma" shall in no case be construed to include occupational disease, as defined in K.S.A. 44-5a01, and amendments thereto.

K.S.A. 2011 Supp. 44-510d(b)(24) states:

> Where an injury results in the loss of or loss of use of more than one scheduled member within a single extremity, the functional impairment attributable to each scheduled member shall be combined pursuant to the fourth edition of the American medical association guides for evaluation of permanent impairment and compensation awarded shall be calculated to the highest scheduled member actually impaired.

[20] ALJ Award at 8-9.

[21] K.S.A. 2011 Supp. 44-501b(b).

[22] K.S.A. 2011 Supp. 44-501b(c).

K.S.A. 2011 Supp. 44-510e(a) states, in part:

> (2) (A) . . . Compensation for permanent partial general disability shall also be paid as provided in this section where an injury results in:
>
> (i) The loss of or loss of use of a shoulder, arm, forearm or hand of one upper extremity, combined with the loss of or loss of use of a shoulder, arm, forearm or hand of the other upper extremity . . . .

K.S.A. 2011 Supp. 44-510h(e) states:

> It is presumed that the employer's obligation to provide the services of a health care provider . . . shall terminate upon the employee reaching maximum medical improvement. Such presumption may be overcome with medical evidence that it is more probably true than not that additional medical treatment will be necessary after such time as the employee reaches maximum medical improvement. The term "medical treatment" as used in this subsection (e) means only that treatment provided or prescribed by a licensed health care provider and shall not include home exercise programs or over-the-counter medications.

"Uncontradicted evidence which is not improbable or unreasonable cannot be disregarded unless shown to be untrustworthy, and is ordinarily regarded as conclusive."[23]

ANALYSIS

1. Claimant's injury by repetitive trauma arose out of and in the course of her employment.

The evidence is conflicting, but two court-ordered and neutral physicians, Drs. Harris and Divelbiss, indicated claimant's repetitive work likely caused her injuries, as did Dr. Kaplan. The Board affirms the judge on this issue.

2. What is the nature and extent of claimant's disability?

According to Dr. Divelbiss, claimant has a 23% whole body impairment involving her arms. Dr. Divelbiss apportioned one-half of claimant's impairment as due to work-related compression neuropathies and one-half to claimant's diabetic neuropathy. Dr. Divelbiss stated claimant's residual symptoms were "more likely to be related to her diabetic neuropathy." Respondent argues Dr. Divelbiss' opinion is uncontradicted, not improbable and not unreasonable, such that his apportionment opinion must be accepted as valid under *Anderson*.

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[23] *Anderson v. Kinsley Sand & Gravel, Inc.*, 221 Kan. 191, Syl. ¶ 2, 558 P.2d 146 (1976).

The judge rejected Dr. Divelbiss' apportionment opinion because the record did not support claimant having diabetic peripheral neuropathy before her work injuries. At oral argument, respondent stated it was not arguing claimant had a preexisting impairment, but rather her current impairment is based on and should be apportioned between both compression neuropathies (carpal and cubital tunnel syndromes) and diabetic neuropathy.

Dr. Divelbiss' opinion that claimant's overall bilateral arm condition is due to both her work injuries and diabetes is supported by other medical evidence. Dr. Rosenthal indicated claimant's presentation was not consistent with entrapment neuropathies alone and claimant likely had diabetic neuropathy. Dr. Walker also indicated there was a peripheral neuropathy component to claimant's complaints. Therefore, three doctors indicated claimant had compression neuropathies and diabetic peripheral neuropathy.

Nevertheless, the basis for Dr. Divelbiss' apportionment opinion is at odds with the statutorily-mandated *Guides*. He used table 16 on page 57 of the *Guides* to rate claimant's impairment. Such table assigns a 10% rating for carpal tunnel entrapment (median nerve at the wrist) and a 10% rating for cubital tunnel entrapment (ulnar nerve at the elbow). Table 16 establishes a floor for impairment. To apportion such figures due to the presence of diabetes would result in claimant being compensated for less than the impairment she is entitled to receive based on the *Guides*. Irrespective of claimant's diabetic peripheral neuropathy, she still qualifies for a 10% impairment to her right arm for carpal tunnel syndrome, a 10% impairment to her right arm for cubital tunnel syndrome, a 10% impairment to her left arm for carpal tunnel syndrome and a 10% impairment to her left arm for cubital tunnel syndrome.

Dr. Divelbiss incorrectly arrived at an overall 23% impairment. Dr. Divelbiss indicated claimant's 10% upper extremity impairments for carpal and cubital tunnel syndromes converted to 6% impairments to the body as a whole. He then combined the two 6% body as a whole ratings for each arm as resulting in a 12% body as a whole impairment for each arm. Next, he combined the left and right 12% arm ratings to arrive at a 23% impairment to the body as a whole.

However, the *Guides* provide a different methodology. A 10% arm impairment for the right wrist combined with a 10% arm impairment for the right elbow results in a 19% impairment to the upper extremity, which converts to an 11% impairment to the body as a whole.[24] The same is true for claimant's left arm. Combining an 11% body as a whole impairment for the converted right arm rating with an 11% body as a whole impairment for the converted left arm rating results in a 21% impairment to the body as a whole. The Board concludes claimant's bilateral carpal and cubital tunnel syndromes resulted in her having a 21% impairment to the body as a whole which is not subject to reduction based on claimant having diabetes.

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[24] See *Guides* at 65 (§ 3.1n), 20 (Table 3) and 322 (Combined Values Chart). Combining and adding are not synonymous under the *Guides*.

3. No TTD overpayment occurred; respondent is not entitled to a credit.

Judge Howard specifically did not believe Mr. Cumberland's suggestion claimant would have been provided accommodated work. The judge concluded claimant was temporarily and totally disabled. The Board affirms on this issue.

4. Claimant is not entitled to future medical treatment.

The record does not contain evidence showing claimant, more probably than not, would require medical treatment for her work injury after she reached MMI. No doctor established it was more probably true than not that claimant "will" require future "medical treatment" as defined by K.S.A. 2011 Supp. 44-510h(e). Claimant conceded this point at oral argument. The Board reverses the underlying Award on this issue.

CONCLUSIONS

The Board concludes:

- claimant sustained injury by repetitive trauma arising out of and in the course of her employment;
- claimant's work-related injuries resulted in a 21% impairment to the body as a whole;
- there was no TTD overpayment; and
- claimant is not entitled to future medical treatment.

AWARD

WHEREFORE, the Board modifies the November 26, 2014 Award as set forth in the "Conclusions" section.

Claimant is entitled to 21.14 weeks of temporary total disability compensation[25] at the rate of $405.87 per week or $8,580.09, followed by 85.86 weeks of permanent partial disability compensation at the rate of $405.87 per week in the amount of $34,848.00, for a 21% whole body impairment, making a total award of $43,428.09, which is ordered paid in one lump sum less amounts previously paid.

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[25] The parties stipulated claimant was paid 21.14 weeks of TTD benefits. (R.H. at 3). This figure differs from the 21 weeks of TTD listed in the judge's calculations.

IT IS SO ORDERED.

Dated this ______ day of May, 2015.

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BOARD MEMBER

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BOARD MEMBER

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Honorable Steven J. Howard